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ABSTRACT

Several studies have shown that sexual assault may lead to psychiatric problems such as depression, fear or anxiety, substance abuse, or sexual distress. As part of an epidemiologic survey to determine base rates of mental disorder in a Los Angeles household population, 3,132 respondents were surveyed about their sexual assault experiences and use of services for mental health reasons. Using a two-stage probability sampling technique, male and female adults were selected from two mental health catchment areas, one comprised primarily of Hispanics and one primarily of non-Hispanic Whites. Respondents reported their lifetime use of general medical services (e.g., non-psychiatric medical doctor, hospital emergency room), specialty mental health services (e.g., psychiatrist, social worker), and human services (e.g., clergy, crisis center). Almost one-quarter of the assaulted respondents (weighted) reported using general medical services compared to less than 9% of the nonassaulted respondents. Weighted percentages among assaulted compared to nonassaulted respondents were about three times higher for use of specialty mental health services (42% versus 14%) and human services (37% versus 11%). These findings are consistent across gender, age, ethnicity and DIS/Diagnostic and Statistical Manual of Mental Disorders-III (DIS/DSM-III) disorder, with use of mental health services more dramatically associated with sexual assault among those with versus without a DIS/DSM-III disorder. (Author/NB)

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Use of Mental Health Services among Sexually Assaulted Community Respondents: The Los Angeles Epidemiologic Catchment Area Project*

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Abstract

As part of an epidemiologic survey to determine base rates of mental disorder in a Los Angeles household population, 3132 respondents were surveyed about their sexual assault experiences and use of services for mental health reasons. Using a two-stage probability sampling technique, male and female adults were selected from two mental health catchment areas, one comprised primarily of Hispanics (83%) and one primarily of Nonhispanic whites (63%). Respondents reported their lifetime use of general medical services (e.g., non-psychiatric medical doctor, hospital emergency room), specialty mental health services (e.g., psychiatrist, social worker), and human services (e.g., clergy, crisis center). Almost a quarter of the assaulted respondents (weighted) reported using general medical services compared to less than 9% of the nonassaulted respondents. Weighted percentages among assaulted compared to nonassaulted respondents were about three times higher for use of specialty mental health services (42% versus 14%) and human services (37% versus 11%). These findings are consistent across gender, age, ethnicity and DIS/DSM-III disorder, with use of mental health services more dramatically associated with sexual assault among those with versus without a DIS/DSM-III disorder.

* The ECA program is a series of five epidemiologic research studies performed by independent research teams in collaboration with staff of the Division of Biometry and Epidemiology of the NIMH. The NIMH principal collaborators are Darrel A. Regier, M.D., M.P.H., Ben Z. Locke, M.S.P.H., and Jack D. Burke, Jr., M.D., M.P.H. The NIMH project officer is Carl A. Taube, Ph.D. The principal investigators and co-investigators from the Los Angeles site are Marvin Karno, Richard L. Hough, Javier I. Escobar, M. Audrey Burnam, and Dianne M. Timbers.

Several studies provide evidence that sexual assault may lead to any number of psychiatric consequences, including depression (Atkeson, Calhoun, Resick & Ellis, 1982; Bagley and Ramsay, 1985; Frank & Stewart, 1984; Kilpatrick, Veronen & Resick, 1979; Peters, 1984), fear or anxiety (Bagley & Ramsay, 1985; Calhoun, Atkeson & Resick, 1982; Kilpatrick, Resick & Veronen, 1981; Kilpatrick, Veronen & Resick, 1979; Sedney & Brooks, 1984), substance abuse (Briere, 1984; Densen-Gerber & Densen-Gerber, 1977; Frank, Turner, Stewart, Jacob & West, 1981; Peters, 1984), and various forms of sexual distress (Becker, Skinner, Abel, Axelrod & Cichon, 1984; Feldman-Summers, Gordon & Meagher, 1979; Orlando and Koss, 1983). Yet, few studies have examined the impact of sexual assault on use of health services; that is, do the sexually assaulted use health services for emotional reasons more often because of their assault? While some data suggest that the prevalence of assault is particularly high among those receiving treatment (Carmen, Rieker & Mills, 1984; Frank, et al., 1981; Rosenfield, 1979), they do not address the temporal order of assault and use of health services or allow for comparisons with nonassaulted individuals. The data reported here, although unable to address the temporal issue, allow for comparison of utilization rates for assaulted and nonassaulted persons. Specifically, this paper examines rates for emotionally-related use of general medical, specialty mental health, and human services as a function of assault, gender, age, ethnicity, and lifetime psychiatric disorder among assaulted and nonassaulted respondents.

Method

The data are from the ongoing Los Angeles Epidemiological Catchment Area (ECA) study, one of five field sites composing the collaborative NIMH-initiated ECA Program. The primary goals of the ECA program are to determine the prevalence and incidence of specific psychiatric disorders and to examine patterns of health service utilization. Respondents at the Los Angeles site were also asked a series of questions regarding lifetime adult and child sexual assault experience.

Subjects. This Wave I household sample consists of 3132 adults (over 18 years of age) from two Los Angeles mental health catchment areas. One catchment area, in East Los Angeles, contained predominantly Hispanic Americans (83%); the other, in the Venice/Culver City area of Los Angeles, contained largely nonhispanic whites (63%) but also many Hispanics (32%). Eighty-seven percent of the Hispanic Americans in the two catchment areas are of Mexican cultural or ethnic origin.

The sample, stratified by catchment area, was selected using a two-stage probability technique, with census blocks as primary sampling units and households as secondary sampling units. The sampling technique gave each household an equal probability of being selected. One adult from each household was then randomly selected for inclusion using the Kish procedure (Kish, 1965). Respondents were interviewed in-person, yielding an overall completion rate of 68%.

In all analyses, data are weighted to adjust for differential probability of sample selection due to varying numbers of adults in each household. In addition, data are adjusted for non-response by weighting to 1980 Census counts of the catchment area household populations, stratified by sex, age, and Hispanic ethnic background.

Measures. The sexual assault instrument was developed at UCLA by Audrey Burnam and Dianne Timbers, both of UCLA, and Vivian Brown of the Didi Hirsch Community Mental Health Center, Culver City, California, in consultation with Suzanne Ageton of the University of Colorado at Boulder and Ellen Ferris of the Center for Prevention and Control of Rape.

Respondents were asked, "In your lifetime, has anyone ever tried to pressure or force you to have sexual contact? By sexual contact I mean their touching your sexual parts, your touching their sexual parts, or sexual intercourse?" Respondents answering "yes" were asked whether they were assaulted before age sixteen (child sexual assault) or at sixteen or older (adult sexual assault).

To determine lifetime use of health services, respondents were asked whether they had ever sought any of the following

services for emotional problems: 1) general medical (e.g., non-psychiatric medical doctor, hospital emergency room); 2) specialty mental health (e.g., psychiatrist, social worker, drug or alcohol clinic); or 3) human services (e.g., clergy, crisis center, self-help group). Each person was classified dichotomously (ever vs. never using) on the three utilization measures.

Ethnicity is classified as Hispanic (primarily Mexican American) or nonhispanic white. Rates for the total sample include Hispanics, nonhispanic whites, and all other ethnic groups. Age is dichotomized at younger then 40 years and 40 years or older. Education is dichotomized at the median years of education within ethnic group (10 among Hispanics, 14 among nonhispanic whites).

Respondents chose whether to take the interview in English or Spanish. The survey instrument format allowed easy switching from one language to another if desired. Although interviewers and respondents were not matched by sex, the interviewer's sex was noted to permit analyzing possible response differences attributable to the match in respondent and interviewer gender.

Results

Rates for use (weighted) of general medical, specialty mental health, and human services as a function of assault, gender, and lifetime disorder are presented in Tables 1 through 3. In addition to the above variables, analyses including age and ethnicity were also conducted. Although Nonhispanic Whites reported greater health service use than Hispanics, age was unrelated to health service use and neither age nor ethnicity interacted with the other predictor variables. Thus age and ethnicity were not included in the model. Lifetime disorder was included in these analyses to ensure that an observed relationship between sexual assault and use of services was not due to an association between utilization of services and probability of having a disorder. Other research suggests that prior psychiatric care may be associated with sexual assault.

Weighted percentages for use of general medical services for mental health showed that almost a quarter of the assaulted

respondents reported using these services compared to less than nine percent of the nonassaulted respondents (see Table 1). Comparable percentages were 32 versus 17 for respondents with a DIS/DSM-III disorder and 11 versus 5 for respondents without a disorder. In all cases, these proportions were significantly different ($p < .05$). When the data were disaggregated by gender, all assaulted groups showed greater use of services, although the differences were statistically significant for female respondents only (both among those with and without a disorder).

Table 2 presents weighted percentages for lifetime use of specialty mental health services. Except for male respondents without a DIS/DSM-III disorder, the proportion who used health services was significantly higher for sexually assaulted than nonassaulted respondents in each category. Examination of the data for all respondents showed a three-fold increase in use of services for assaulted compared to nonassaulted respondents (42 versus 14). Comparable figures were 52 versus 28 for respondents with a DIS/DSM-III disorder and 27 versus 9 percent for respondents without a disorder.

Weighted percentages for lifetime use of human service providers also showed significantly greater use among sexually assaulted respondents for all comparisons except among males with no disorder (see Table 3). For all respondents, the use of services is about three times higher in the assaulted compared to the nonassaulted (37% versus 11%). Among those with a disorder, 45% of the sexually assaulted reported using human service providers compared to 23 of nonassaulted respondents. Comparable figures for those without a disorder are 25 versus 6 percent.

Discussion

These data present compelling evidence that mental health service use is greater among the sexually assaulted than the nonassaulted. These findings are stable regardless of gender, age, ethnicity, and DIS/DSM-III disorder. (The somewhat weaker results for males are likely an effect of smaller cell sizes). It appears that our data are not completely explained by the hypotheses that the vulnerable individual (someone with a psychiatric disorder) is more likely to be assaulted and also

more likely to display higher utilization rates irrespective of an assault experience. For use of specialty mental health services and human services providers, the comparisons of sexually assaulted with nonassaulted respondents indicated greater differences among those without a disorder than with a disorder. In other words, among those without a disorder, the proportion using services was four times greater for those who have been sexually assaulted than for those who have not. Among respondents with a disorder, the proportion of the assaulted using services was twice that of the nonassaulted. For general medical providers, the proportion of respondents using health services was about twice as large for assaulted compared to nonassaulted respondents, regardless of the presence or absence of a disorder. In sum, our data suggest that the experience of sexual assault is more dramatically associated with higher use of services for mental health reasons among individuals without a history of DIS disorder than among those with a disorder.

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Table 1. Lifetime Use of General Medical Services for Mental Health as a Function of Lifetime Sexual Assault, Gender, and Lifetime Disorder.

	Male			Female			All Respondents		
	No DIS Disorder	With Disorder	Both	No DIS Disorder	With Disorder	Both	No DIS Disorder	With Disorder	Both
Not Assaulted	3.3[a] (.7)[b]	15.4 (1.6)	7.5 (.8)	6.9 (1.0)	20.0 (2.6)	10.0 (.9)	5.2 (.6)	17.3 (1.4)	8.7 (.6)
Assaulted	.9 (.9)	20.7 (3.8)	13.5 (2.7)	15.6 (3.3)	39.2 (4.5)	29.2 (3.2)	11.0 (2.2)	32.4 (3.0)	23.7 (2.1)
All Subjects	3.3 (.7)	16.0 (1.6)	8.0 (1.6)	7.6* (.9)	25.3* (2.2)	12.9* (.9)	5.6* (.6)	20.3* (1.4)	10.5* (.6)

a) Proportion of respondents
b) Standard error
* Assaulted differ from non-assaulted at $p<.05$.

Table 2. Lifetime Use of Specialty Mental/Health Services for Mental Health as a Function of Sexual Assault, Gender, and Lifetime Disorder.

	Male			Female			All Respondents		
	No DIS Disorder	With Disorder	Both	No DIS Disorder	With Disorder	Both	No DIS Disorder	With Disorder	Both
Not Assaulted	7.3[a] (.9)[b]	24.9 (2.0)	13.3 (.8)	9.5 (1.2)	33.1 (3.4)	15.2 (1.3)	8.5 (.8)	28.2 (1.8)	14.2 (.8)
Assaulted	10.1 (3.8)	43.3 (6.3)	31.2 (4.2)	34.9 (4.2)	57.4 (4.7)	47.8 (3.2)	27.1 (3.3)	52.2 (3.7)	42.1 (2.8)
All Subjects	7.4 (.9)	27.2* (2.0)	14.7* (.9)	11.8* (1.3)	39.5* (2.8)	20.1* (1.3)	9.8* (.9)	32.9* (1.6)	17.5* (.9)

a) Proportion of respondents
b) Standard error
* Assaulted differ from non-assaulted at $p<.05$.